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# THE DOD HUMANITARIAN AND CIVIC ASSISTANCE PROGRAM CONCEPTS, TRENDS, MEDICAL CHALLENGES

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Maj. Linda L. Ebling

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14. ABSTRACT

The U.S. Department of Defense (DOD) supports worldwide humanitarian assistance activities as part of military operations other than war (MOOTW). This study is a qualitative and quantitative analysis of one aspect of MOOTW: the DOD Humanitarian and Civic Assistance (HCA) Program. This analysis defines and evaluates the HCA program in the context of MOOTW and proposes the emergence of several trends as well as challenges. This study also assesses the purposes and limits of HCA (under Title 10, United States Code) and differentiates between humanitarian assistance (HA) and HCA. Current trends highlight past, present, and potential benefits of this program. Challenges involve: implementing program improvements; measuring program performance and effectiveness; and defining military roles relevant to training, long term benefits, and the politico-military interface. Methodology for this study includes: (1) a literature review, (2) analysis of a 1993-94 U.S. Government General Accounting Office (GAO) report entitled ?Department of Defense: Weaknesses in Humanitarian and Civic Assistance Programs,? (3) analysis of program data, (4) evaluation of medical after-action reports, and (5) interviews with personnel involved in various aspects of HCA. Reports on medical HCA conducted in USSOUTHCOM by medics associated with Air Force Special Operations Command (AFSOC) serve to tie together the interrelated themes of this study and support conclusions relevant to trends, benefits, challenges, suggested improvements, and suggested areas for future research.

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## Disclaimer

The views expressed in this academic research paper are those of the author and do not reflect the official policy or position of the US government or the Department of Defense.

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## *Preface*

*Fundamental progress has to do with the reinterpretation of basic ideas*

—Alfred North Whitehead

The decade of the 1990s is one that will be remembered and described variously, with accounts referencing: the post-Cold War years, a new world order, an information superhighway, emerging technologies, global conflicts, and much uncertainty. It has been and continues to be a period of revolutionary change. Various articles and publications discussing current US military or political affairs reveal a common thread of *"re"* words: *restructure, reorganize, reengineer, rethink, relook, regroup, reinvent, reinterpret* . . . and the list goes on. All of this is in response to the demands of *change*.

The principles which the military has historically applied to the planning and execution of *war* have likewise been *reevaluated* for their relevance to the spectrum of operations now challenging the Services. These operations range from *war* to *military operations other than war (MOOTW).* As we consider just one aspect of MOOTW, humanitarian and civic assistance (HCA), it becomes clear how this different set of missions presents some new challenges for today's military. Combine that with our resource-constrained environment and the reasons for *reorganizing, rethinking, and reengineering* become obvious.

With this complex and dynamic environment in view, this research study examines the DOD Humanitarian and Civic Assistance program, and proposes the emergence of several

trends as well as challenges. Medical-specific challenges are given special attention, and are also considered in the context of the "big picture." This wider focus serves to remind us that specific health services or other assistance provided at a given point in time may not have an observable effect at the moment, but may in the *long term* result in improvements in the health and welfare of a nation.

An exploration of these complex issues requires analysis of information from various sources as well as the collective expertise of many. The author wishes to specifically acknowledge the following individuals and organizations for their support of this analytical process: Suellyn Raycraft, OASD(SO/LIC); Major Dayna McDaniel, HQ AFSOC/SGA, lLt Manny Torres, 919th Special Operations Wing/SG; MSgt Jose Ciceraro, USSOUTHCOM/SCSG, and the special operations forces medical personnel of the Air Force Special Operations Command at Hurlburt Field, Florida. Their past, present, and future involvement in MOOTW and humanitarian and civic assistance collectively represents a *long term benefit* for our nation.

## *Abstract*

The U.S. Department of Defense (DOD) supports worldwide humanitarian assistance activities as part of military operations other than war (MOOTW). This study is a qualitative and quantitative analysis of one aspect of MOOTW: the DOD Humanitarian and Civic Assistance (HCA) Program. This analysis defines and evaluates the HCA program in the context of MOOTW and proposes the emergence of several trends as well as challenges. This study also assesses the purposes and limits of HCA (under Title 10, United States Code) and differentiates between humanitarian assistance (HA) and HCA. Current trends highlight past, present, and potential benefits of this program. Challenges involve: implementing program improvements; measuring program performance and effectiveness; and defining military roles relevant to training, long term benefits, and the politico-military interface. Methodology for this study includes: (1) a literature review, (2) analysis of a 1993-94 U.S. Government General Accounting Office (GAO) report entitled "Department of Defense: Weaknesses in Humanitarian and Civic Assistance Programs," (3) analysis of program data, (4) evaluation of medical after-action reports, and (5) interviews with personnel involved in various aspects of HCA. Reports on medical HCA conducted in USSOUTHCOM by medics associated with Air Force Special Operations Command (AFSOC) serve to tie together the interrelated themes of this study and support conclusions relevant to trends, benefits, challenges, suggested improvements, and suggested areas for future research.

## Chapter 1

# Introduction

Darkness obscures the horizon as a 75-year-old woman slowly walks along a mountain trail in Ecuador, making her way to a nearby village. As dawn breaks, she finally arrives at the small one-story building where she and others anticipate receiving some type of health care from the American medical team. Dressed in her "Sunday best," she joins the others already waiting in line outside the makeshift "clinic." There is quiet chatter as they candidly talk about their experiences with previous similar health care projects. If it's like the others, they'll attend health education classes, and then receive a medical evaluation and some type of treatment from a doctor, dentist, nurse, or other health worker.

The team for this particular health project includes 15 US Air Force medical personnel and additional local health workers. The team is well prepared for the mission, "armed" with health education materials, immunizations, medicines, bandages, and other medical supplies. As final preparations are made to begin the clinic, both the medical team and the villagers know it will be a long and busy day, but there will be many benefits realized. Most will leave the clinic feeling at least a little better than when they arrived.

At the same time and in the same village, a US Air Force civil engineering team of 25 begins a school construction project, along with a project to clean up the local water

distribution system. Also that same day, an Army veterinarian team treks to specified locations in the host country to provide veterinary care of local farm animals.[1]

These diverse activities are all part of the same project, part of military exercises and training, and part of a concept, a tool and a program called *humanitarian and civic assistance* or *"HCA"* . . . the focus of this inquiry.

The purpose of this research study is to clearly define and evaluate the DOD HCA program in the context of MOOTW. The overall thesis proposes the emergence of several trends and challenges, which are arguably caused and/or influenced by the current dynamic environment. The research methodology includes both a qualitative and quantitative analysis, building on three interrelated themes to support the overall thesis.

The first and main theme focuses on defining and describing the DOD HCA program in the context of MOOTW, with evaluation of the purposes and limits as legislated by Title 10, United States Code (USC). This aspect of the study considers the overall HCA program, specifically analyzing: recent trends, documented weaknesses, recent improvements, and various challenges. Although the focus is primarily qualitative, the trend analysis relevant to program expenditures is quantitative in nature.

The second theme narrows the focus to medical HCA: the medical readiness training benefit, AFSOC medical experience in USSOUTHCOM, and performance measurement using mission essential task lists (METLs). The discussion of medical HCA ties together the interrelated themes and also supports overall conclusions relevant to trends, program benefits, challenges, suggested improvements, and suggested areas for future study.

The third and final theme considers the influence of politics, the politico-military interface, and the role of the military relevant to promoting or facilitating long term

benefits for the populations served. This theme highlights how HCA represents one of many political tools of our government, with great potential benefits for host nations. The obvious question to be answered is: How does the military fit in? A *brief* rundown of some historical notes regarding the emergence of this political tool and involvement of the military (including AFSOC) will provide some additional background information to set the stage for this analysis. This also sets the framework for the progression of this analysis, starting with "big picture" of MOOTW and eventually narrowing the focus to medical HCA.

From an historical perspective, HCA projects have represented one means for DOD units to receive various types of operational training, to include medical readiness training. Both active duty forces and the reserve components (RC) have participated in these projects worldwide, dating back to "nation assistance" projects conducted in Latin America during the early 1960s.[2] In 1985, Congress authorized these projects under the name "humanitarian and civic assistance (HCA)" and in 1987 legal authority for the HCA program was defined in Title 10.[3]

The politico-military environment during the earlier nation assistance projects was quite different than it is today. The increased emphasis on MOOTW presents *today's* US military force with a variety of new missions as well as ambiguous challenges.[4] This tells of the complexity inherent in supporting our national military strategy of flexible and selective engagement, involving support of a broad range of activities.[5] Nation assistance has been and continues to be an important element of that *range of activities*.

During the 1990s, Air Force Special Operations Command (AFSOC) medical personnel participated in nation assistance and HCA in conjunction with AFSOC foreign

internal defense (FID) missions in support of USSOUTHCOM objectives.[6] Reserve personnel attached to AFSOC now participate regularly in medical HCA, effectively incorporating them into their annual unit deployment schedules during the 1990s, as well. Given current trends, special operations forces (SOF) medics may play an increasingly larger role in future HCA and HA operations.[7] Given the scope of MOOTW, this could involve many and varied roles for medical personnel of all Services. Just how many and how varied becomes quickly evident, as the next chapter begins this analysis with a look at HCA in the context of *military operations other than war.*

**Notes**

[1]This information is based on written accounts and experiences of medical personnel during HCA conducted in the 1990s in USSOUTHCOM, as well as personal experiences of the author.

[2]Rudolph C. Barnes, "Civic Action, Humanitarian and Civic Assistance, and Disaster Relief," *Special Warfare*, vol 2-4 (Fall 1989), 34.

[3] Department of Defense: Changes Needed to the Humanitarian and Civic Assistance Program (GAO/NSAID-94-57, Nov 2, 1993), 3.

[4] Maj Aryea Gottlieb and Maj Steve Black, *The Role of SOF in Military Operations Other Than War: A Primer* (Air Force Special Operations Command, 31 March 1996), 4.

[5] *National Military Strategy of the United States of America*, Executive Summary (1995),i, and FM 100-23-1/FMFRP 7-16/NDC TACNOTE 3-07.6/ACCP 50-56/USAFEP 50-56, *Multiservice Procedures for Humanitarian Assistance Operations* (October 1994), 1-8–1-9.

[6] This study is unclassified; however, some sources remain classified and will not be specifically referenced. Air Force Special Operations Forces Medical Elements (SOFME) from the 16th Special Operations Wing (previously the 1st SOW), Hurlburt Field, Florida have supported the AFSOC FID mission during the 1990s. SOFMEs (comprised of one flight surgeon and two medical technicians) participated in medical HCA in conjunction with FID, generally augmenting another Air Force or Army medical for the HCA. This included participation in exercises and providing medical care to the host populace.

[7] The USSOCOM Humanitarian Assistance Medical Working Group met 25-28 October 1996 at MacDill AFB to discuss issues and concepts relevant to future employment of SOF medical personnel in humanitarian assistance activities. Updated policy and guidance is yet to be published. Information from the *United States Special Operations Forces 1996 Posture Statement.* (Washington D.C.: Office of the Assistant Secretary of Defense (SO/LIC), 1996) provides background information relevant to concepts being applied in medical policy development.

# Chapter 2

# MOOTW and HCA: Concepts and Trends

*Participation in MOOTW is critical in the changing international security environment. Although the goals and end states may not be crystal clear, you should spare no effort in planning and executing MOOTW.*

—John M. Shalikashvili
Chairman of the Joint Chiefs of Staff

## Definitions, Distinctions and Operational Relationships: HCA and HA

Military operations other than war include a *range of operations* which are indicative of the multifaceted nature of our world security environment. As defined in Joint Pub 3-07, MOOTW ". . . encompasses the use of military capabilities across the range of military operations short of war. These military actions can be applied to complement any combination of the other instruments of national power and occur before, during and after war."[1] Defining MOOTW and what is included in this range of operations illustrates both the complexity and the ambiguity of this concept, as it includes both non-combat and combat operations and activities.[2]

Joint Pub 3-07 also identifies 16 types of MOOTW, to include: arms control, combating terrorism, DOD support to counterdrug operations, enforcement of sanctions / maritime intercept operations, enforcing exclusion zones, ensuring freedom of navigation and overflight, *humanitarian assistance (HA),* military support to civil authorities

(MSCA), *nation assistance* / support to counterinsurgency, noncombatant evacuation operations (NEO), peace operations (PO), protection of shipping, recovery operations, show of force operations, strikes and raids, and support to insurgency.[3] These operations typically involve varying combinations of air, land, sea, space, and special operations forces (SOF), along with government organizations and agencies, nongovernmental organizations (NGO), and private voluntary organizations (PVO).[4]

It's clear just where HA fits into MOOTW, but how about HCA? The answer is found by considering what is included in *nation assistance*, as illustrated in Figure 1.[5]

| **NATION ASSISTANCE PROGRAMS** |
|---|
| ***Security Assistance*** |
| ***Foreign Internal Defense*** |
| ***Humanitarian and Civic Assistance***<br>*Provided in conjunction with military operations and exercises.*<br>*Must fulfill unit training requirements that incidentally create humanitarian benefits to the local populace* |

**Figure 1. Nation Assistance Programs**

Since *HA* is a separate category of MOOTW and *HCA* is a program under nation assistance, what distinguishes the two? While operationally the distinguishing lines may blur, there are distinctions relevant to legislative authority, doctrine, definitions, program procedures and funding sources.

The DOD Humanitarian and Civic Assistance Program is authorized under Title 10, United States Code, Section 401. This legislation authorizes the Department of Defense and the military department to conduct HCA in conjunction with authorized military operations if the Service Secretary determines that the military activities will promote: (1)

the security interests of both the United States and the host country, and (2) the specific operational readiness skills of the military members who participate in the activity.[6] Both the active and reserve components work with their foreign counterparts on the following types of authorized projects: (1) Medical, dental, and veterinary care provided in rural areas of a country; (2) construction of rudimentary surface transportation systems; (3) well drilling and construction of basic sanitation facilities; (4) rudimentary construction and repair of public facilities; and (5) detection and clearance of land mines, including training, education, and technical assistance relevant to this.[7]

Review and approval of HCA projects involve interagency coordination at several echelons.[8] The process begins with a request from the host nation government to the US Embassy. After the US Embassy endorses the project, the US unified combatant commander for the region (for example, USCINCSOUTH) determines if US forces can provide the requested activity or support based on projected deployment schedules. HCA proposals for the regional combatant commands (USSOUTHCOM, USPACOM, USEUCOM, USCENTCOM, USACOM) are submitted annually through the Joint Staff (J-4 Directorate) to the Office of the Secretary of Defense (OSD). At the DOD level, the Assistant Secretary of Defense for Special Operations and Low-Intensity Conflict [OASD(SO/LIC)], has the lead for the interagency review and approval process. The following agencies review/approve project proposals: DOD, Department of State, and the US Agency for International Development (USAID). These agencies ensure proposed projects comply with HCA legislation and US foreign policy objectives. After completing the interagency review/approval process (with final approval through the Political Military Bureau in the State Department and the USAID Bureau for Program and Policy),

OASD(SO/LIC) informs the combatant commands and the Joint Staff regarding formal approval of specific HCA projects. The project nomination and review/approval process is an approximately 18-month process.[9] Once again, these are projects covered under Title 10, US Code, Section 401.[10]

There are several other Title 10 humanitarian programs involving military assistance which fall under the big umbrella of "humanitarian assistance" (not HCA).[11] Detailed discussion of these is beyond the scope of this paper. Briefly however, Section 2551, Humanitarian Assistance, covers the most notable program. Section 2551 authorizes funds for transportation of humanitarian relief and various other humanitarian activities worldwide. Other major programs include: Section 402, Transportation of Humanitarian Relief Supplies to Foreign Countries; Section 404, Foreign Disaster Assistance; and Section 2547, Excess Non-lethal Supplies: Humanitarian Relief.

A word on terminology: Considering the various programs noted, not to mention the multitude of civilian sector programs, it's not surprising there is at times confusion over who does what and when and for what reasons. A scan of the literature from the 1980s and 90s on this topic (looking at military related articles) reveals various terms and acronyms used interchangeably,[12] to include: humanitarian assistance (HA), (sometimes used as the umbrella term and sometimes not), humanitarian and civic assistance (HCA),[13] humanitarian civic action (HCA),[14] medical HCA,[15] civic action (CA),[16] military civic action (MCA),[17] medical civic action program (MEDCAP),[18] joint military medical exercise (MEDFLAG),[19] and medical readiness training exercise (MEDRETE).[20] Since the 1994 publication of DOD Directive 2205.2[21] and the 1995 publication of Joint Pubs 3-07 and 4-02,[22] a favorable trend toward more consistent use of established terminology

(HCA and HA) is noted. This is evident both in after-action reports and in journal articles. Updates and additions to Service and unified combatant command doctrine and policy should likewise reflect this consistency, enhancing the concept of "jointness."[23] The terms MEDCAP and MEDRETE are still used to refer to specific medical readiness training and exercises, but defined within the context of HCA.[24]

One of the publications lending clarity to the distinction between HA and HCA is Joint Pub 4-02, Doctrine for Health Service Support in Joint Operations. This well-written document provides the following doctrine and definition distinctions:

> *HCA* activities are designed to provide assistance to [the host nation] (HN) populace in conjunction with US military operations or exercises. *Humanitarian assistance* operations are conducted to relieve or reduce the results of natural or man-made disasters or other endemic conditions such as human pain, disease, hunger, or privation that might present a serious threat to life or that can result in great damage to or loss of property until the appropriate civilian agencies can accept the responsibility. While HCA represents a scheduled event, planned in conjunction with and as part of military training exercises, *HA* operations are generally conducted in response to a specific humanitarian crisis or emergency. [25]

While these distinctions exist, both programs focus efforts on assisting the local populace with various types of assistance that their government cannot provide *at the time.* From the medical standpoint, the actual types of medical support provided with HA and HCA may be the same or very similar, or may vary widely due to a crises situation, political events, or environmental factors relevant to the host country. All things considered, there is not one standard or typical deployment for HA or HCA from an operational perspective, but established legislation, policy and procedures lend consistency and a framework for program administration and planning activities.

Another HCA/HA distinction of note is funding sources. The military departments fund HCA programs of the regional Combatant Commands. The Air Force funds USCENTCOM, the Army funds USEUCOM and USSOUTHCOM, and the Navy funds USACOM and USPACOM. OASD(SO/LIC) summarizes funding guidelines as follows:

> HCA funding covers only incremental expenses, such as costs for consumable materials, supplies, and services, if any, that are reasonably necessary to provide the HCA. Funding does not include costs associated with the military operation (e.g., transportation, personnel expenses, petroleum, oil, lubricants, repair of equipment, etc), which likely would have been incurred whether or not the HCA was provided. [26] [These expenses are unit funded and are budgeted for as part of annual costs for unit deployments for training (DFTs) and other programmed training activities. DOD does not track these expenses or include them with reports relevant to DOD HCA program expenditures.]

In contrast, Title 10 addresses HA and other humanitarian activities under specified sections previously noted. Various sources and mechanisms, including congressional appropriations, provide funds for these activities. HA funding for worldwide humanitarian assistance (Section 2551 of Title 10) was somewhat restricted until 1996. For FY96, Congress appropriated funds in a new Overseas, Humanitarian, Disaster and Civic Aid (OHDACA) account. This funding source adds flexibility to the overall HA program, as the account is without restriction from both a legal and policy standpoint, and allows U.S. military forces to carry out diverse humanitarian projects worldwide.[27]

To summarize, while these HCA/HA distinctions exist relevant to legislative authority, doctrine, definitions, program procedures and funding sources, both categories of programs include focused efforts to aid or benefit a regional populace with various types of assistance that their government is unable to provide *at the time.*

## Current Statistical Trends: How Big is the DOD Program?

DOD Directive 2205.2, *Humanitarian and Civic Assistance (HCA) Provided in Conjunction with Military Operations*, was published in October 1994. This document formalized and implemented more detailed program procedures, including more detailed data reporting. This is reflected in OASD(SO/LIC) annual reports to Congress, compiled from comprehensive end-of-year reports provided by each of the regional combatant commands. A trend analysis and comparison of data from the FY95 and FY96 OASD reports shows recent trends relevant to deployment locations, total program expenditures, and expenditures for various types of projects.

During the past two years, 55 countries hosted HCA projects in conjunction with scheduled military training and operational deployments.[28] Appendix A provides a snapshot of the scope of the overall DOD program, as it illustrates countries where these projects took place in FY95 and FY96.[29] As OASD(SO/LIC) continues to track and report this data, trends can be identified relevant to regional requirements.

A comparison of data for the combatant commands also indicates trends relevant to program expenditures. The author extracted data from FY95 and FY96 OASD/(SO/LIC) annual reports to accomplish a trend analysis. Table 1 provides the results of this quantitative analysis, showing the comparative size of the HCA program in the combatant command regions, and comparing total program expenditures with those for health-related or medical categories of projects. This includes health-related expenditures for direct patient care and overall improvements in the health condition of the region, such as medical evaluation and treatment, dental care, preventive medicine, public health, and veterinary medicine.

**Table 1. DOD HCA Program Expenditures**

| Costs of Health-Related Categories of Projects* vs. Total HCA Project Costs | | | | |
|---|---|---|---|---|
| | **FY 1995** | | **FY 1996** | |
| *Combatant Commands* | *Health Project Costs* | *Total HCA Costs* | *Health Project Costs* | *Total HCA Costs* |
| USACOM | $165,133 | $1,220,838 | $144,604 | $1,240,000 |
| USCENTCOM | $148,000 | $473,000 | $436,000 | $558,000 |
| USEUCOM | $165,000 | $290,500 | $251,000 | $251,000 |
| USPACOM | $508,382 | $1,007,360 | $328,606 | $953,065 |
| USSOUTHCOM | $500,660 | $2,374,000 | $715,487 | $2,689,091 |
| **TOTAL—Health Projects** | **$986,793** | | **$1,875,697** | |
| **TOTAL—HCA Projects** | | **$5,365,698** | | **$5,691,156** |
| **Health Project % of Total $** | **18.4%** | | **33.0%** | |

**Source:** Raw data/information from OASD(SO/LIC) annual reports, FY 95 and FY 96.
*Includes medical care, dental care, preventive medicine, public health, and veterinary medicine.

Several statistics stand out, and may be indicative of trends for the future. While overall program expenditures in FY96 increased by $330K, expenditures for the health-related or medical categories of projects significantly increased from $986,793 (18.4% of the total program) in FY95 to $1,875,697 (33.0% of the total program) in FY96.[30] Based on DOD estimates, overall health project expenditures will likely increase for FY97.[31] USSOUTHCOM has by far the largest program, with 44% of total DOD program expenditures in FY95 and 47% in FY96. This includes funding of HCA programs (including health-related projects) in 12 of the 19 countries in the SOUTHCOM area of responsibility.[32] Health project expenditures for SOUTHCOM were 21.1% of their total HCA program in FY95 and 26.6% in FY96. These will likely increase during FY97 as well.[33] In fact, the current SOUTHCOM medical planner indicated programming of $1.2M for Title 10 FY97 health-related projects for USSOUTHCOM. Their estimated expenditures will probably exceed $1 million, representing a nearly $300K increase for

SOUTHCOM health-related projects in FY97. USSOUTHCOM will expend these funds in the areas of responsibility highlighted at Appendix A. The increase in expenditures for health-related projects is not surprising to those involved with various aspects of HCA. Host countries are currently requesting more health-related projects, which they consider beneficial to their country as well as being politically safe.[34] The issue of ensuring and measuring a *long-term benefit*, however, is a topic of great debate. Some argue this is a significant limitation or weakness of the program.[35] Perspectives relevant to this will be debated later, along with consideration of medical projects and the politics of HCA.

To set the stage for that debate, however, a more complete analysis of documented weaknesses in the DOD program is presented in the next chapter. This also includes discussion of DOD actions to address these weaknesses and the impact of that on current programs.

**Notes**

[1]Joint Pub 3-07, *Joint Doctrine for Military Operations Other Than War.* (Washington DC: Joint Chiefs of Staff, June 1995), I-2. AFDD 2-3. *Military Operations Other Than War* (1995) complements the joint doctrine. Joint Pub 3-07.3, Joint Tactics, Techniques, and Procedures for Peacekeeping Operations (1994) includes discussion of medical roles, but most notably provides another illustration of the complexity of MOOTW.

[2]LtCol Ann E. Story and Maj Aryea Gottlieb. "Beyond the Range of Military Operations." Joint Force Quarterly (Autumn 1995) 99. Story and Gottlieb suggest that although Joint Pub 3-07 established much needed doctrine for MOOTW, the model of the range of military operations is confusing and ambiguous. The authors proposed a new model, "the military operational framework."

[3]Ibid., III-1.

[4]Joint Pub 3-0, *Doctrine for Joint Operations.* (Washington DC: Joint Chiefs of Staff, February 1995), V-1.

[5]Joint Pub 3-07, III-9.

[6]Title 10, United States Code, Chapter 20, Section 401.

[7]Ibid.

[8]DODD 2205.2, *Humanitarian and Civic Assistance (HCA) Provided in Conjunction with Military Operations*, (October 1994), 1- 6.

## Notes

[9]Suellyn Raycraft, DOD HCA Program Manager, OASD/(SO/LIC), interviewed by author, 15 January 97. Similar information was received from MSgt Jose Ciceraro, Supt, Theater Medical Programs, USSOUTHCOM/SCSG, interviewed by the author, 22 January 1997.

[10]Humanitarian and Civic Assistance Program of the Department of Defense, FY95 and FY96, OASD(SO/LIC) file copies of annual reports to Congress.

[11]Maj Rhonda M. Smith and Maj Barbara J. Stansfield. "The Process of Providing Humanitarian Assistance: A Department of Defense Perspective" (Unpublished AFIT MS Thesis. Air University, September 1995), 2-2 - 2-5.

[12]Tom Barry, "U.S. Military Civic Action Programs and Democratization in Central America," *Democracy Backgrounder* Vol. 1, No.3 (September 1995): 1.

[13]William Ward et al, "A Critical Part of Nation Assistance," *Military Review (*March 1993): 36.

[14]Col Charles Hardin Hood, "Humanitarian Civic Action in Honduras, 1988," Military Medicine (June 1991): 292.

[15]Medical After Action Report files, 1990-1996, for 919th Special Operations Wing (SOW) Medical Squadron deployments and 1st SOW (now 16th SOW) Special Operations Forces Medical Elements (SOFME) deployments. This includes 25 documents from historical records of HQ AFSOC/SG and excerpts from 6 SOS (FID) after-action reports relevant to augmentation of medical HCA in conjunction with FID missions.

[16]Barry, 1.

[17]Ibid.

[18]Rourk Sheehan. MEDFLAG Zimbabwe. *Soldiers*, (January 1992), 1-2.

[19]Ibid.

[20]William Ward et al.

[21]DODD 2205.2, 1- 6.

[22]Joint Pub 3-07, Joint Doctrine for Military Operations Other Than War (June 1995) sets forth doctrine to govern joint operations, including ongoing involvement with joint military, multinational and interagency/civilian operations. Additionally, Joint Pub 4-02, Doctrine for Health Service Support in Joint Operations (April 1995), delineates requirements for the health service support (HSS) system as well as HSS aspects of joint planning, special operations, and military operations other than war.

[23]Michael C. Vitale, "Jointness by Design, Not Accident," *Joint Force Quarterly*, (Autumn 95), 24-30.

[24]William Ward et al and Rourk Sheehan.

[25]Joint Pub 4-02, *Doctrine for Health Service Support in Joint Operations*. (Washington DC: Joint Chiefs of Staff, 26 April 1995), IV-4.

[26]OASD(SO/LIC) FY96 HCA Program Report for Congress.

[27]John Zavales, OASD(SO/LIC), "Information Paper: Other Humanitarian Assistance Activities," presented at USSOCOM Humanitarian Assistance Medical Working Group Conference, 25-28 October, 1996, MacDill AFB, Florida.

[28] Raw data/information from OASD(SO/LIC) annual reports, FY 95 and FY 96.

[29] Ibid.

## Notes

[30] Ibid.

[31]Suellyn Raycraft, DOD HCA Program Manager, OASD/(SO/LIC), interviewed by author, 15 January 97. These are OASD(SO/LIC) projections for FY97.

[32]USSOUTHCOM FY1996 HCA Program—Year End Report.

[33]Suellyn Raycraft, OASD(SO/LIC) and MSgt Jose Ciceraro, USSOUTHCOM/ SCSG, 15 and 22 January 1997 interviews previously noted.

[34]Ibid.

[35]Col Lee D. Schinasi, "America's Unfocused Humanitarian and Civic Assistance Programs: Is Anybody in Charge? Where are We Going?" (Unpublished Individual Study Project. US Army War College, Carlisle Barracks, April 1993), 18-19.

# Chapter 3

# Weaknesses and Improvements in the DOD HCA Program

> *Government is famous for its endless figures and forms. To an outsider, it seems like an industry that pays an enormous amount of attention to numbers. People in government are always counting something or churning out some statistical report. But most of this counting is focused on inputs: how much is spent, how many people are served, what service each person received. Very seldom does it focus on outcomes, on results. This is true in part because measuring results is so difficult.*
>
> —David Osborne and Ted Gaebler
> *Reinventing Government*

## U.S. Government Accounting Office Review: Process and Findings

During 1992-93, the GAO conducted a review of the DOD HCA Program. It published its final report in November 1993.[1] In April 1994, the GAO National Security and International Affairs Division presented a summary of their findings in testimony before the Subcommittee on Oversight and Investigations, Committee on Armed Services, House of Representatives.[2] Testimony before the House focused on two major issues relevant to USPACOM and USSOUTHCOM: (1) the extent and costs of the program, and (2) the implementation and monitoring of the program by DOD. GAO provided a general assessment of the overall program, but particularly focused on USSOUTHCOM. Considering the size and complexity of this worldwide program, it is understandable why GAO limited the scope of their evaluation. In fact, one of the major conclusions of the

GAO analysis, "full extent of assistance is unknown" is ironically a self-indictment of our government capabilities to comprehensively analyze complex government programs involving multiple organizations and funding sources. Keeping in view this complexity, this discussion provides the most salient features of the DOD Humanitarian and Civic Assistance Program as seen through the eyes of the GAO in the 1992-94 time frame. The next section then summarizes the recommendations made by GAO and most importantly, provides an overview relevant to what DOD has done in follow-up of these recommendations.

GAO identified the following three major categories of issues:

1. Full Extent Of Assistance Unknown. This included criticism that DOD did not report all costs associated with the program, such as transportation and personnel costs for deployments.
2. Weaknesses In Program Implementation. This included assessments that: some projects did not meet foreign policy objectives, training benefits of some projects was questionable, and some projects did not meet country needs. GAO testimony emphasized the statutory requirement that " . . . DOD was to issue regulations on how to implement the HCA Program." At the time of the GAO analysis, DOD had not yet issued a directive.
3. Commands Do Not Evaluate HCA Projects. This segment of the testimony again highlighted SOUTHCOM and PACOM, noting: "Our review indicated that the Southern and Pacific Commands were not monitoring projects to determine their *effectiveness* (italics added). The Southern Command's Program Analysis and Evaluation chief said he had not evaluated projects because DOD had not provided guidance."

## GAO Recommendations and DOD Follow-up

The GAO report and testimony concluded with the following recommendations:

> . . . we recommended that DOD (1) provide Congress a more reasonable estimate of the costs of providing humanitarian assistance [HCA], (2) issue an implementing directive for conducting HCA activities, (3) ensure that projects contribute to U.S. foreign policy objectives and are supported by the host country, (4) ensure that the training soldiers receive from working on HCA projects promotes their military readiness skills, and (5) ensure

that commands evaluate projects to determine their *effectiveness.* (Italics added)

What has DOD done in follow-up of these recommendations? Addressing this involves consideration of improvements DOD has made, as well as the response of the combatant commands.

DOD "answered the mail" regarding these recommendations by issuing an implementing directive in October 1994: DOD Directive 2205.2, *Humanitarian and Civic Assistance (HCA) Provided in Conjunction with Military Operations.* The directive addresses all recommendations noted by GAO and supports accomplishment of the management and oversight responsibilities of OASD(SO/LIC), the combatant commands and others involved in the program. This publication also formalizes program procedures, facilitating DOD efforts to coordinate, review, and monitor the program. This includes data tracking and more detailed reports relevant to program activities. Evaluation of annual reports accomplished by OASD(SO/LIC) and USSOUTHCOM since publication of the directive provide evidence that DOD has followed through with the recommendations of the GAO.[3]

The DOD reports to Congress are based on detailed end-of-year reports from the combatant commands. As required, OASD(SO/LIC) provides Congress an overview of the preceding fiscal year HCA projects, giving the "big picture" view of training benefits derived by military units, along with a description of health-related, civil engineering and other service projects accomplished in host countries. They also report costs as recommended by GAO, with one significant exception. The SO/LIC report documents expenditure of authorized Title 10 funds, but does not report transportation and personnel costs. In their testimony to Congress, GAO highlighted what "costs" were not reported

using the following example: ". . . Southern Command estimated that a small deployment of 14 to 60 troops with an average stay of 14 days would cost about $315,000, with transportation and per diem accounting for $250,000 or about 71 percent of the cost."[4] The GAO report implied DOD should also track and report these costs. DOD basically refuted this suggestion, as these are operational and training costs that, as noted in the directive ". . . likely would have been incurred whether or not the HCA was provided."[5] Medical after action reports reflect tracking of this cost data at the unit level, however.[6]

A final point worth noting pertains to the response of combatant commands following publication of the DOD directive relevant to HCA. OASD(SO/LIC) indicated that reports from the combatant commands are more comprehensive and they address program compliance with Title 10, Section 401, as well as GAO issues. For example, the USSOUTHCOM FY96 end-of-year report for the HCA program begins with an overview, noting: "The SOUTHCOM HCA program improved U.S. Armed Forces ability to plan, deploy personnel and equipment, train on mission essential task list (METL) tasks, conduct civic assistance, conduct military operations other than war, and redeploy. The primary objective of improving the skills and abilities of soldiers, sailors, airmen and marines in austere overseas environments was achieved."[7]

The nearly 50-page report addresses the training value of deployments, benefits to host nations, cost data, description of projects by country/location, achievement of objectives, country team coordination and key points of contact for each project. The report also addresses benefits to the local populace, providing *subjective* assessments relevant to improvements in health and living conditions. Statements are made about *results* of the projects, but there is no supporting data to substantiate actual *effectiveness*

in benefiting the host nation. For example, simply reporting that a certain number of individuals were treated for particular ailments resulting in improvement in overall health of the population doesn't quantify the benefit. On the other hand, if a program is designed to quantify benefits or outcomes, project reports would substantiate benefits with statements such as this: "As a result of implementing a focused program to prevent and treat communicable diseases in children, the child mortality rate decreased 30 percent and school attendance increased 40 percent in country X during 1996." That statement quantifies an outcome. Combatant commands do not report this type of information, as they are not required to do so based on the legislated purpose for this program. Again, long term benefits for the host populations are desired, but not required. As a result, statements regarding program results and effectiveness (relevant to long term benefits) remain primarily subjective assessments.

In summary, analyzing weaknesses and recent improvements in the DOD HCA program reveals both ongoing challenges as well as noteworthy improvements in ensuring this program fulfills the purposes it was designed for under Title 10. On the improvement side, DOD has followed through with GAO recommendations, issuing and implementing policies and procedures to improve oversight and management of the program. Data and documents produced by DOD and USSOUTHCOM substantiate those improvements. On the flip side, in considering the ongoing challenges and areas for potential improvement, it is necessary to re-emphasize what has/has not been addressed to this point and what will be addressed in the final chapter.

The analysis to this point primarily has considered *process improvements*, with substantiated changes made by OASD(SO/LIC) to *result in* improvements in management

and oversight of the program. The question remains: How do these improvements translate to what is happening in the combatant commands and in the field? Answering this requires additional *performance measurement* to address the specific GAO recommendations that DOD ". . . ensure the training soldiers receive promotes their military readiness skills" and ". . . ensure commands evaluate projects to determine their *effectiveness*" (italics added). This represents an ongoing challenge for the combatant commands, the evaluation of which is another study in itself. The next chapter, however, illustrates *performance* on a smaller scale, with evaluation of the medical readiness training benefit of HCA. This chapter also gives one more consideration of the larger framework within which HCA "operates" and highlights the policies and politics of HCA.

**Notes**

[1]Department of Defense: Changes Needed to the Humanitarian and Civic Assistance Program (GAO/NSAID-94-57, Nov 2, 1993).

[2]April 19, 1994 Statement of Joseph E. Kelley, Director-in-Charge, International Affairs Issues, National Security and International Affairs Division, U.S. Government Accounting Office.

[3]FY95 and FY96 annual reports of USSOUTHCOM and OASD(SO/LIC).

[4]April 1994 GAO testimony to Congress.

[5]DODD 2205.2, para D-9.

[6]A sampling of reports and data files were reviewed, including medical after-action reports from AFSOC and AFRES for FY95, FY96 and FY97.

[7]FY96 USSOUTHCOM HCA End-of-Year Report

# Chapter 4

# The Medical HCA Experience: Benefits and Challenges

> *He receives hope in future benefits who recognizes a benefit that has already taken place.*
>
> —Flavius Magnus Aurelius Cassiodorus, c.490-c.583

We began this analysis with consideration of the complex picture of MOOTW and with definitions relevant to what HCA is and isn't. In detailing what it is, the program was defined in terms of its purposes, as outlined in Title 10: ". . . promote the security interests of both the United States and the host country and promote the specific operational readiness skills of the military members who participate in the activity."[1]

Translating that to medical HCA, the primary purpose is clearly medical readiness training, which happens to include an incidental medical benefit to the host population. Given that medical readiness training is the focus, this final chapter considers briefly the scope and perceived benefits of this training and how effectiveness is measured. Considering the incidental medical benefit to the host population, the incidental medical goal of promoting a long term benefit is also discussed.

## Medical Readiness Training: Results, Effectiveness, Outcomes

The challenge of accomplishing medical readiness training requirements along with fulfilling day-to-day peacetime patient care requirements received special attention from

DOD medical leaders in the aftermath of Operation DESERT STORM.[2] This was prompted by GAO reports which identified Service deficiencies in the conduct of medical readiness training.[3] The Air Force Medical Service (AFMS) initiated a review of its existing medical readiness training program and subsequently published AFI 41-106, Medical Readiness Planning and Training. Initiatives to refine and reengineer established training programs and procedures continue, reflecting an ongoing emphasis by the Air Force Surgeon General.[4] This also supports the FY 1998-2003 Medical Program Guidance published by the Office of the Secretary of Defense for Health Affairs.[5]

The Air Force Medical Service has historically used various methods and means to medically prepare for potential contingencies described in the Joint Strategic Capabilities Plan (JSCP).[6] One means is through medical readiness training exercises (MEDRETES) conducted primarily by the reserve components in conjunction with HCA.[7] The entire process and the medical activities relevant to planning, deployment, execution and redeployment is now simply referred to as "medical humanitarian and civic assistance" or "medical HCA." Although the terms MEDRETE and medical HCA are used inter-changeably, medical HCA is used here, as it coincides with terminology in current joint doctrine.

In exploring the medical readiness training aspects of medical HCA conducted in USSOUTHCOM by AFSOC and AFSOC-gained personnel, the author reviewed approximately 25 medical after-action reports, medical training summaries and medical excerpts from non-medical after-action reports.[8] These reports span the time frame from 1990 to the present time. The author also reviewed information in these reports with medical personnel from the 919th SOW (Eglin AFB/Duke Field, Florida) and the 16th

Operations Medical Flight (Hurlburt Field, Florida) in order to verify the authors interpretation of this information.[9] Although no two deployments were exactly alike, medical HCA participants identified many of the same training benefits. The following illustrates how these medical HCA projects can and do provide a valuable training tool, given accomplishment of the following activities surrounding these deployments.

Medical units and personnel scheduled to participate in each HCA complete extensive preparations through ongoing unit training. This includes various deployment planning activities, cultural training, country briefings and medical-specific preparations based on the nature and location of the mission. Comprehensive checklists are used to ensure required actions are accomplished for all phases: pre-deployment, deployment, mission execution, redeployment and post-deployment. Units basically rehearse procedures applicable to wartime contingency situations as well.

Once deployed to the HCA location(s), personnel experience the challenge of deployment site "set up" and "take down" (sometimes multiple times, with clinics set up at several locations). Personnel gain valuable cultural experience in the process of working with host nation health care personnel and the local populace.[10] Several after-action reports also referenced challenging opportunities for practical application of leadership skills.[11] Joint training is another documented benefit, as the HCA involve working with varying numbers of personnel from other branches of the military. For example, one HCA involved the 919th Medical Squadron, part of an Army civil affairs battalion, an Army veterinarian team and various support personnel from the 919th SOW.[12]

After-action reports included comprehensive data and "lessons learned." Medical personnel thoroughly identified problems and recommendations for each HCA, then used

this information for training and preparation prior to future HCA. In spite of a number of problems and issues identified with each mission, all reports emphasized the valuable medical readiness training benefit of each MEDRETE and the HCA project as a whole. Most significantly, personnel noted they received training they could not receive at their US location (i.e., through the deployment process and environment). Personnel also completed both specialty-specific and unit mission-specific training.[13]

Considering the consistently positive assessments regarding the benefits and effectiveness of this medical readiness training leads to the question: How are results and effectiveness measured? The answer: through use of unit mission essential task lists (METLs). METLs represent a standardized means to ensure personnel are training on tasks identified to effectively accomplish assigned missions. Conditions and standards associated with tasks provide objective measures to assess proficiency in performance.[14] The 919th Medical Squadron has placed more emphasis on the use of METLs during the past two years and continues to refine the process of performance measurement. Increased use of METLs by units also coincides with the Chairman of the Joint Chiefs of Staff (CJCS) emphasis on the use on joint mission essential task lists (JMETL), supporting requirements to operate in a joint environment.[15]

In their innovative writing "Reinventing Government," Osborne and Gaebler make some observations relevant to the art of performance measurement which have wide application to government programs, including the military.[16] Two keys points relevant to performance measurement are: (1) there is a vast difference between measuring process and measuring results, and (2) there is a vast difference between measuring efficiency and measuring effectiveness.[17] Relating this to the current HCA program, USSOUTHCOM's

annual reports document units participating in HCA use METLs in accomplishing and evaluating training.[18] As a result, they are not just considering process and efficiency; they are measuring results and effectiveness. Medical HCA training materials used by medical units referenced in this report also document the ongoing use of METLs. The USSOUTHCOM and OASD(SO/LIC) annual reports however do not elaborate on how units use METLs to document training or overall program effectiveness.

A third and final point made by Osborne and Gaebler relevant to performance measurement is: There is an important difference between "program outcomes" and broader "policy outcomes."[19] Applying this to HCA program outcomes for USSOUTHCOM, one could conclude this equates to "enhancing the operational readiness skills of military units" or for medical HCA, "verifying a measurable medical readiness training benefit." The broader policy outcome would relate again to what is stated in Title 10: "promoting the security interests of the United States and the host country." Herein lies the disconnect for medical personnel, the delta between the legislated (and observable) policy outcomes as stated above and what medical personnel would like to see in terms of a "non-legislated" health policy outcome and long term benefit for the host population. That leads to the final segment of this analysis, reverting back to some big picture considerations: the policies and politics of HCA.

## Policies and Politics: HCA and the Issue of a Long-Term Medical Benefit

Given current procedures for the conduct of medical HCA, it is evident there is an incidental medical benefit to the populations served.[20] In some SOUTHCOM areas, medical HCA projects currently provide nearly fifty percent of the health care in the

region.[21] With some medical HCA, there is also evidence that both short term and long term benefits are being derived.[22] To ensure and measure long term benefits for all medical HCA however represents quite another challenge. Host governments do not use a standard mechanism for measuring benefits, given that current policy (Title 10 Section 401) does not require such measurement.

The challenge of planning for and measuring a long-term medical benefit requires that a host country have an operationally mature (and adequately funded) Ministry of Health. Based on interviews with the 919th Medical Squadron planner and the USSOUTHCOM Surgeon's Office HCA planner, most of the host countries do not have the same level of interest in statistics gathering and planning for long term benefits as their US medical counterparts. In fact, host country participants in medical HCA do not provide USSOUTHCOM/SCSG with any written summary or an after-action report (like those that military units accomplish post-deployment).[23] Political priorities of the host governments generally focus attention on other areas. The bottom line: this is an area that military medical personnel do not have control over, nor should they. How might this be improved on or remedied and what role should the military play?

There are two suggestions offered here relevant to the "non-legislated" yet desirable outcome of measurable long-term benefits for host nations. The first suggestion is an interagency initiative to promote and measure long term benefits, using medical HCA as a starting point to test the concept. To effectively implement this requires the cooperative actions of the host country, the US country team, the combatant command and participating units. The rationale for an interagency initiative is based on the roles of the "players" in this interagency program. For example, although *military* medical providers

may plan activities to promote a long-term benefit for a particular HCA, the *political* realities drive the outcome. What a host country specifically *requests* for the HCA project and what our foreign policy objectives *dictate* take precedence. An initiative to focus specific efforts for specific regions, with the host country actively engaged in the process could standardize the process regionally.

The second suggestion would serve to promote military support of this initiative and pertains to the use of METLs and JMETLs.[24] In the medical area, mission-essential task lists are currently used to ensure and document *effectiveness* of the medical readiness training accomplished by units. The suggestion here is to take the use of METLs and JMETLs one step further and develop task lists which address facilitating or promoting long term medical benefits for specific regions. Although USSOUTHCOM (and the other combatant commands) document use of METLs and JMETLs in training and exercises, the difference proposed here is addressing *specific conditions and standards based on specific host country requirements.* These must be congruent with foreign policy objectives and desired end-states for the various regions.

A "test project" involving a host country with an established Ministry of Health is a suggested means of testing the concept. The process and rationale is basically as follows:

> Based on previous medical HCA experiences, each combatant command would suggest at least one country in their region for a "test project." The selection would also be based on the approved HCA projects for the year. Before designating a particular medical HCA as a test project, agreement by the respective US country team and the host nation Ministry of Health is required. The Ministry of Health would then determine what health issue or condition to measure. JMETLs, developed by the combatant command medical staff, would help focus the efforts of both the Ministry of Health and the military medical team conducting the HCA. The combatant command medical staff and military medical team would serve as facilitators in the process. The level of involvement of the Ministry of

> Health and any other host nation medical personnel will determine the success of the project. Their involvement will also determine whether the processes are established to ensure and measure long term benefits for medical HCA projects in their country.

As participants in this process, military medical personnel are not responsible for ensuring and measuring a long term benefit, but they can (and do) make substantial contributions in *supporting* or *facilitating* those efforts. The Ministry of Health in the host country should bear the burden of effort in making this work in their country. Based on information obtained in this analysis, the author believes these suggestions are applicable and feasible for medical HCA in USSOUTHCOM. However, the applicability and feasibility of these suggestions for *all* of the combatant commands and for *all* aspects of HCA is not known and is a suggested area for further study.

**Notes**

[1]Title 10, United States Code, Chapter 20, Section 401.

[2]Dr. Stephen C. Joseph. *Medical Program Guidance, FY 1998-2003*. (Office of the Secretary of Defense for Health Affairs, 1996).

[3]Suzann Chapman, "The Quest for Medical Readiness," *Air Force Magazine*, (November 1995), 32-35. This article (along with a host of other medical articles and reports post-DESERT STORM) reviewed issues and challenges relevant to military medical readiness. Additionally, the GAO conducted analyses of the Services' medical preparedness for DESERT STORM and noted deficiencies in Service training programs.

[4]HQ AETC/SGPM and HQ AMC/SGPM, "Humanitarian Assistance Education Program for USAF Medical Personnel (HAE)." (1996 Internet source document: http://www.ophsa.brooks.af.mil/1PAGERS.HTM#HAE).

[5] Dr. Stephen P. Joseph, *Medical Program Guidance, FY 1998-2003.*

[6] The Joint Strategic Capabilities Plan (JSCP) is a classified planning document that contains guidance to the combatant commanders (CINCs) and Service Chiefs for accomplishing military tasks and missions based on current military capabilities. (AFSC Pub 1). Key JSCP concepts are also covered in Joint Pub 5-0, *Doctrine for Planning Joint Operations* (Washington DC: Joint Chiefs of Staff, April 1995), II-10, 11, 12.

[7] William Ward et al, "A Critical Part of Nation Assistance," *Military Review* (March 1993): 36.

[8] The bulk of these medical reports were from MEDRETES/Medical HCA conducted by the 919th SOW Medical Squadron. The other reports were medical accounts by

## Notes

SOFMEs assigned to Special Operations Squadrons at Hurlburt Field as they augmented FID deployments and worked with medical units tasked with HCA during 1990-94.

[9] 1Lt Manny Torres (919th Medical Planner) and medical technicians of the 16th Operations Medical Flight, interviewed by the author, 14-15 January 1997.

[10] TSgt Janis Blaney, "Blood, Sweat and Tears." *Citizen Airman* (January 1994), 2-3. This article contains highlights of information contained in the medical after-action report for the exercise Cabanas Fuertas Defensas '93 held in Panama.

[11] Ibid, p. 3.

[12] After-Action Report SA-6238, Puerto Francisco de Orellana—Ecuador, 919th Medical Squadron/SG, 27 April 1996.

[13] AFI 41-106 requires that medical personnel receive both specialty-specific and mission-specific training. Specialty-specific training is based on the individual's specialty and mission-specific training is based on the unit's assigned missions.

[14] John R. Ballard and LtCol Steve C. Sifers. "JMETL: The Key to Joint Proficiency." *Joint Force Quarterly*, (Autumn 1995), 95.

[15] Ballard and Sifers, 95.

[16] David Osborne and Ted Gaebler, "Reinventing Government," (New York: Penguin Books, 1993), 349-353.

[17] Ibid, p 350-351.

[18] FY96 USSOUTHCOM HCA End-of-Year Report, cover letter.

[19] Osborne and Gaebler, p. 352-353.

[20] FY96 USSOUTHCOM HCA End-of-Year Report

[21] William Ward et al, 39.

[22] Ibid, 37 and 39.

[23] MSgt Jose Ciceraro, Supt, Theater Medical Programs, USSOUTHCOM/SCSG, interviewed by author, 29 January 1997.

[24] See Ballard and Sifers article. See definitions provided in *Glossary* of this paper.

## Chapter 5

# Conclusion

> *The journey of a thousand leagues begins with a single step. So we must never neglect any work of peace within our reach, however small.*
>
> —Adlai Stevenson

As the light of day fades on the horizon, the last patients leave the village "clinic" and begin their journey back to their homes, with medicines and health education literature in hand. The medical team convenes to reflect on the day's events and discuss the plan for tomorrow's clinic. The day was long and busy; very tiring, but very rewarding as well. The sights and sounds of this day in Ecuador are remembered: the cherub-like faces of the babies, the crying children, the sad eyes of the little girl waiting for an immunization, the challenges of "crowd control," the crippled man, the expressions of *gracias* . . . and many other "pictures" etched in the memory of each team member.

In others areas of the village, the civil engineering and veterinary teams are also winding down their work activities, physically tired and with "pictures" of the day likewise a memory. Although the work activities are diverse, the teams share a sense of accomplishment and a common hope. They put forth their best efforts as they train and participate in an operational readiness exercise. At the same time, they hope that what they do in this military training deployment will have a lasting benefit.

The various pictures brought to mind by this humanitarian and civic assistance project are snapshots of the complexity of MOOTW. They capture our shifting military focus . . . from waging war to waging peace. The current HCA program illustrates the dynamics of this changing focus, with trends, benefits, challenges, and areas for improvement revealed during this analysis.

Regarding *benefits*, the HCA program has proven its value as a means of enhancing the operational readiness skills of military personnel. The benefit of medical readiness training was used as an example, with emphasis on the importance of using METLs as performance measures. Continued emphasis on the use of METLs is key to ensuring that mission-essential training requirements are accomplished and that training *results* and *effectiveness* are measured.

The *key challenges* presented by this DOD program are simply those created by the increasing military roles with MOOTW. Perhaps the most significant is the training challenge: maintaining the "readiness" to perform a full spectrum of operations.

Another *challenge* is presented by the current and projected *trend* toward more medical HCA. At a minimum, more medical projects will provide more opportunities for quality medical readiness training, along with health education and a health care benefit for the host populace. A caveat however, is that more projects must not serve the role of replacing what host nations should be striving to provide for their people. In view of this, a reasonable goal of the military in those health-related projects is to *facilitate* a host nation's efforts to promote long term improvements. While these "politically safe" projects clearly occupy a viable niche in MOOTW, the policies and politics present the challenge (and difficulty) of ensuring and measuring a long-term benefit. Osborne and Gaebler's

concepts regarding *program outcomes* and *broader policy outcomes* served to highlight these challenges.

Regarding *program improvements*, DOD's publication of the directive for HCA in 1994 resulted in documented improvements in management and oversight of the program. How these improvements tie in with program *results and effectiveness* "in the field" however is not as well documented by the combatant commands and requires further evaluation. The GAO recommendation that the combatant commands evaluate projects must be addressed in a way that illustrates more than subjective assessments. *Results* and *effectiveness* for different aspects of the program (e.g., training, host country benefits) should be measured and substantiated by data as much as possible. Combatant commands should also include this information in their end-of-year HCA reports to OASD(SO/LIC). This would further substantiate combatant command follow-up of GAO recommendations.

Two measures suggested by the author would facilitate the process of *performance measurement* as well as the process *of promoting a long-term benefit*. One suggestion is an interagency initiative using medical HCA as "test projects." The second suggestion (supporting this initiative) is to expand the use of METLs and JMETLs to promote and facilitate long term benefits for specific regions. For medical HCA, efforts on the part each country's Ministry of Health would be of primary importance in making this work.

The process of conducting this analysis revealed some *areas for further study*. Two key areas involve: (1) an assessment of how commands are evaluating HCA projects and (2) the applicability and feasibility of the interagency initiative (and expanded use of

JMETLs) to *all* combatant command HCA projects. An additional area for future research would be a follow-up study of the trends identified in this paper.

Finally, while the fundamental purpose of the US armed forces is to fight and win our nations wars, we must also be prepared to effectively accomplish *military operations other than war*. As one mission in MOOTW, humanitarian and civic assistance will continue to prove its value in supporting our national military strategy of flexible and selective engagement, promoting our nation's interests, enhancing the operational readiness skills of military personnel, and (incidentally) providing substantial benefits to host country populations.

# Appendix A

# FY95-96 HCA Projects

**Table 2. Locations of DOD (HCA) Projects, FY95-96**

| *Country* | *FY 1995* | *FY 1996* | *Country* | *FY 1995* | *FY 1996* |
|---|---|---|---|---|---|
| 1. Antigua | X | | 29. Jordan | X | X |
| 2. Argentina | X | | 30. Kenya | | X |
| 3. Bahamas | X | X | 31. Kiribati | | X |
| 4. Barbados | | X | 32. Laos | | X |
| 5. Bangladesh | X | | 33. Mali | X | X |
| 6. ***Belize*** * | X | X | 34. Maldives | | X |
| 7. Benin | | X | 35. Mongolia | X | |
| 8. Bolivia | X | X | 36. Mozambique | | X |
| 9. Botswana | | X | 37. New Guinea | X | X |
| 10. ***Brazil**** | X | | 38. ***Nicaragua**** | | X |
| 11. Cambodia | X | X | 39. Oman | X | |
| 12. Comoros | X | | 40. ***Panama**** | X | X |
| 13. ***Costa Rica**** | X | X | 41. ***Paraguay**** | | X |
| 14. Cote d'Ivoire | X | | 42. ***Peru**** | X | X |
| 15. Djibouti | X | X | 43. Philippines | X | X |
| 16. Dominica | X | X | 44. Rwanda | | X |
| 17. Dominican Rep | X | X | 45. Senegal | X | |
| 18. ***Ecuador**** | X | X | 46. Solomon Is. | X | X |
| 19. ***El Salvador**** | X | X | 47. St Kitts/Nevis | X | X |
| 20. Eritrea | X | X | 48. St Lucia | | X |
| 21. Fiji | X | X | 49. St Vincent | X | X |
| 22. Ghana | X | X | 50. Thailand | X | X |
| 23. ***Guatemala**** | X | X | 51. Tonga | X | |
| 24. ***Guyana**** | X | X | 52. Trinidad/Tobago | X | |
| 25. Haiti | X | X | 53. Tuvalu | X | |
| 26. ***Honduras**** | X | X | 54. Vanuatu | X | X |
| 27. Indonesia | X | X | 55. Zimbabwe | X | |
| 28. Jamaica | X | X | | | |

**Source:** Office of the Assistant Secretary of Defense (SO/LIC), FY95 and FY96 annual reports.

*USSOUTHCOM Area of Responsibility

## *Glossary*

| | |
|---|---|
| ACSC | Air Command and Staff College |
| AFDD | Air Force Doctrine Document |
| AFI | Air Force Instruction |
| AFMS | Air Force Medical Service |
| AFSOC | Air Force Special Operations Command |
| ARC | Air Reserve Component |
| AU | Air University |
| | |
| CA | civil affairs |
| CJCS | Chairman of the Joint Chiefs of Staff |
| | |
| DOD | Department of Defense |
| DODD | Department of Defense Directive |
| DOS | Department of State |
| DFT | deployment for training |
| | |
| FID | foreign internal defense |
| | |
| GAO | Government Accounting Office |
| | |
| HA | humanitarian assistance |
| HCA | humanitarian and civic assistance |
| HSS | health service support |
| | |
| JMETL | joint mission essential task list |
| JSCP | Joint Strategic Capabilities Plan |
| | |
| MEDCAP | Medical Civic Assistance Program |
| MEDFLAG | Medical Red Flag exercise |
| MEDRETE | Medical Readiness Training Exercise |
| METL | mission essential task list |
| MOOTW | military operations other than war |
| MSCA | military support to civil authorities |
| | |
| NEO | noncombatant evacuation operation |
| NGO | nongovernmental organization |

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| OASD | Office of the Assistant Secretary of Defense |
| OHDACA | Overseas Humanitarian, Disaster and Civic Aid |
| PO | peace operations |
| PVO | private voluntary organization |
| RC | reserve component |
| SG | surgeon general |
| SO/LIC | Special Operations/Low Intensity Conflict |
| SOF | special operations forces |
| SOFME | Special Operations Forces Medical Element |
| SOW | special operations wing |
| USACOM | United States Atlantic Command |
| USAID | United States Agency for International Development |
| USC | United States Code |
| USCENTCOM | United States Central Command |
| USCINCSOUTH | Commander in Chief, United States Southern Command |
| USEUCOM | United States European Command |
| USPACOM | United States Pacific Command |
| USSOCOM | United States Special Operations Command |
| USSOUTHCOM | United States Southern Command |

**civil affairs.** The activities of a commander that establish, maintain, influence, or exploit relations between military forces and civil authorities, both governmental and nongovernmental, and the civilian populace, in a friendly, neutral, or hostile area of operations in order to facilitate military operations and consolidate operational objectives. Civil affairs may include performance by military forces of activities and functions normally the responsibility of local governments. These activities may occur prior to, during or subsequent to other military actions. They may also occur, if directed, in the absence of other military operations. (Joint Pub 1-02)

**command-linked tasks.** Tasks that depict the seams between supported and supporting commands. Command linked tasks are key to the accomplishment of command or agency JMETs. (CJCSM 3500.4A)

**condition.** A variable of the operational environment or situation in which a unit, system, or individual is expected to operate that may effect performance. (CJCSM 3500.4A)

**foreign internal defense.** Participation by civilian and military agencies of a government in any of the action programs taken by another government to free and protect its society from subversion, lawlessness, and insurgency. (Joint Pub 1-02)

**health service support.** All services performed, provided, or arranged by the Services to promote improve, conserve, or restore the mental or physical well-being of personnel. These services include, but are not limited to, the management of health services resources, such as manpower, moneys, and facilities; preventive and curative health measures; evacuation of the wounded, injured or sick; selection of the medically fit and disposition of the medically unfit; blood management; medical supply, equipment

and maintenance thereof; combat stress control; and medical, dental, veterinary, laboratory, optometric, medical food, and medical intelligence services. (Joint Pub 4-02)

**host nation.** A nation which receives the forces and/or supplies of allied nations and/or NATO organizations to be located on, or to operate in, or to transit through its territory. (Joint Pub 1-02)

**humanitarian and civic assistance.** Assistance provided in conjunction with military operations and exercises, and must fulfill unit training requirements that incidentally create humanitarian benefit to the local populace. HCA programs are provided under Title 10 US Code Section 401. In contrast to emergency relief conducted under HA operations, HA programs generally encompass planned activities. (Joint Pub 3-07)

**humanitarian assistance.** Programs conducted to relieve or reduce the results of natural or manmade disasters or other endemic conditions such as human pain, disease, hunger, or privation that might present a serious threat to life or that can result in great damage to or loss of property. Humanitarian assistance provided by US forces is limited in scope and duration. The assistance provided is designed to supplement or complement the efforts of the host nation civil authorities or agencies that may have the primary responsibility for providing humanitarian assistance. (Joint Pub 1-02)

**joint mission essential task list.** A list of joint tasks considered essential to the accomplishment of assigned or anticipated missions. A JMETL includes associated conditions and standards and may identify command-linked and supporting tasks. (CJCSM 3500.4A)

**joint mission essential task.** A task selected by a joint force commander from the Universal Joint Task List (UJTL) deemed essential to mission accomplishment. (CJCSM 3500.4A)

**medical civic action program.** A term used in EUCOM and PACOM medical planning and training documents which is synonymous with medical humanitarian and civic assistance (HCA). Also called MEDCAP.

**medical readiness training exercise.** An exercise which utilizes host nation medical assets and US military medical assets to provide both medical readiness training and nation assistance. Also called "MEDRETES," the term is synonymous with "medical humanitarian and civic assistance (HCA)." To support the joint doctrine effort to promote continuity in term usage, medical HCA is now the more frequently used term. (USSOUTHCOM/SCSG, AFSOC/SG and AFRES/SG documents)

**military operations other than war.** Encompasses the use of military capabilities across the range of military operations short of war. These military actions can be applied to complement any combination of the other instruments of national power and occur before, during and after war. Also called MOOTW. (Joint Pub 1-02)

**military support to civil authorities.** Those activities and measures taken by the DOD Components to foster mutual assistance and support between the Department of Defense and any civil government agency in planning or preparedness for, or in the application of resources for response to, the consequences of civil emergencies or attacks, including national security emergencies. Also called MSCA. (Joint Pub 1-02)

**mission essential task list.** A compilation of collective mission essential tasks which must be successfully performed if an organization is to accomplish its wartime mission(s). (FM 25-100)

**mission essential task.** A collective task in which an organization must be proficient to accomplish an appropriate portion of its wartime mission(s). (FM 25-100)

**mission.** The task, together with the purpose, that clearly indicates the action to be taken and the reason therefor. (CJCSM 3500.4A)

**nation assistance.** Civil and/or military assistance rendered to a nation by foreign forces within that nation's territory during peacetime, crises or emergencies, or war based on agreements mutually concluded between nations. Nation assistance programs include but are not limited to, security assistance, foreign internal defense, humanitarian and civic assistance, other US Code Title 10 (DOD) programs, and activities performed on a reimbursable basis by federal agencies or international organizations. (Joint Pub 1-02)

**nongovernmental organizations.** Refers to transnational organizations of private citizens that maintain a consultative status with the Economic and Social Council of the United Nations. Nongovernmental organizations may be professional associations, foundations, multinational businesses or simply groups with a common interest in humanitarian assistance activities (development and relief. "Nongovernmental organizations" is a term normally used by non-US organizations. Also called NGO. (Joint Pub 1-02)

**private voluntary organizations.** Private, nonprofit humanitarian assistance organizations involved in development and relief activities. Private voluntary organizations are normally US-based. Also called PVO. (Joint Pub 1-02)

**standard.** The minimum acceptable proficiency required in the performance of a particular task under a specified set of conditions. Standards [for JMETs] are established by a joint force commander. (CJCSM 3500.4A)

**supporting task.** Specific activities that contribute to the accomplishment of a joint mission essential task. Supporting tasks are accomplished at the same command level or by subordinate elements of a joint force (i.e., joint staff, functional components, etc). (CJCSM 3500.4A)

**task.** A discrete event or action, not specific to a single unit, weapon system, or individual that enables a mission or function to be accomplished. (CJCSM 3500.4A)

**United States country team.** The senior, in-country, United States coordinating and supervising body, headed by the Chief of the United States diplomatic mission, usually an ambassador, and composed of the senior member of each represented United States department or agency. (Joint Pub 1-02)

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